Running head: Outpatient Pharmacy Civilian Prescription

Outpatient Pharmacy

Civilian Prescription Pathway Process Improvement

Mark S. Hernandez

Naval Medical Center, Portsmouth, VA

U.S. Army-Baylor University

20000113 014

REPORT DOCUMENTATION PAGE

Public reporting burden for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington, VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (0704-0188), Washington, DC 20503.

1. AGENCY USE ONLY (Leave blank)	2. REPORT DATE March 1998	3. REPORT TYPE AND DATES COVERED FINAL REPORT (07-97 TO 07-98)

4. TITLE AND SUBTITLE

Outpatient Pharmacy Civilian Prescription Pathway Process Improvement

5. FUNDING NUMBERS

6. AUTHOR(S)

LT Mark S. Hernandez, MSC, USN

7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES)

Naval Medical Center
620 John Paul Jones Circle
Portsmouth, Virginia 23708-2197

8. PERFORMING ORGANIZATION REPORT NUMBER

32c-98

9. SPONSORING / MONITORING AGENCY NAME(S) AND ADDRESS(ES)

US ARMY MEDICAL DEPARTMENT CENTER AND SCHOOL
BLDG 2841 MCCS-HRA US ARMY-BAYLOR PROGRAM IN HCA
3151 SCOTT RD SUITE 1412
FORT SAM HOUST TEXAS 78234-6135

10. SPONSORING / MONITORING AGENCY REPORT NUMBER

11. SUPPLEMENTARY NOTES

12a. DISTRIBUTION / AVAILABILITY STATEMENT

Approved for public release; Distribution is unlimited.

12b. DISTRIBUTION CODE

13. ABSTRACT (Maximum 200 words)

Naval Medical Center Portsmouth, outpatient pharmacy civilian prescription pathway was examined to determine if process changes could be made to improve the process of filling civilian provider ordered prescriptions through the outpatient pharmacy. The current pathway is outdated and does not reflect the many changes that have occurred within the MHS. Examination into the Composite Health Care System (CHCS), third party collection process, and prescription processing methodologies were performed to determine where pathway process changes could be made and incorporated. It was determined that process changes could be employed which would improve the civilian prescription pathway. The benefits of incorporating the revised pathway for filling civilian prescriptions would greatly increase beneficiary satisfaction, improve pharmacy staff efficiency in the delivery of goods and services, and almost eliminate the manual review of other health insurance forms. Other significant benefits would include a significant reduction in the backlog of third party claims, a reduction in over time paid to employees to catch up, a reduction in overhead costs associated with processing third party claims, and increased reimbursement from the third party collections program to the outpatient pharmacy.

14. SUBJECT TERMS

Prescription Pathway Process Improvement

15. NUMBER OF PAGES

65

16. PRICE CODE

17. SECURITY CLASSIFICATION OF REPORT N/A	18. SECURITY CLASSIFICATION OF THIS PAGE N/A	19. SECURITY CLASSIFICATION OF ABSTRACT N/A	20. LIMITATION OF ABSTRACT UL

Acknowledgments

There are many people who deserve special acknowledgment and special mention. Among those are my wife and two sons. My family provided tremendous support and encouragement, which helped motivate me to complete this project and the Masters Degree Program. I sincerely appreciate and acknowledge the many professionals within the Pharmacy, Resource, and Management Information Departments of Naval Medical Center Portsmouth who unselfishly devoted their time and imparted their professional talents to assist me in the accomplishment of this Graduate Management Project. Without their expertise and sincere willingness to help me learn, this project would have significantly been more difficult to accomplish. More specifically, I want to acknowledge the Medical Center's Pharmacy Staff and notably the Department Head, Captain M. Alexander, MSC, USN and Assistant Department Head, Commander B. Nolan, MSC, USN. Without their total commitment and support, accomplishment of this project could not of been feasible. These professionals took me under their instruction and greatly enhanced my education. Lastly, I acknowledge the total support my preceptor, Captain D. Thompson, MSC, USN provided me throughout the residency phase of the program. He devoted time to give counsel and guidance while continually stressing the importance of learning. His support was paramount in the success of this Graduate Management Project.

Abstract

As the Military Health System (MHS) continues to transform towards a managed care model, components of quality, access, and cost have increasing become key components of how the MHS is now being managed. Everyone is encouraged to maximize efficiencies and to examine and improve at all levels the way patient care services are delivered. Naval Medical Center Portsmouth (NMCP), outpatient pharmacy civilian prescription pathway was examined to determine if process changes could be made to improve the process of filling civilian provider ordered prescriptions through the outpatient pharmacy. The current pathway is outdated and does not reflect the many changes that have occurred within the MHS. Examination into the Composite Health Care System (CHCS), third party collection process, and prescription processing methodologies were studied to determine where pathway process changes could be made and incorporated. After a thorough study of these various components, it was determined that process changes could be employed which would improve the civilian prescription pathway. Such changes would positively affect the quality, access, and cost of delivering pharmaceuticals. The direct benefits of incorporating the revised pathway for filling civilian prescriptions would greatly increase beneficiary satisfaction, improve pharmacy staff efficiency in the delivery of goods and services, and almost eliminate the manual review of other health insurance forms. Other significant benefits would

include a significant reduction in the backlog of third party claims, a reduction in over time paid to employees to catch up, a reduction in overhead costs associated with processing third party claims, and increased reimbursement from the third party collections program to the outpatient pharmacy. This project examined and recommends changes to the civilian prescription pathway that are not only applicable to NMCP, but significant enough to warrant application within other Department of Defense (DoD) outpatient pharmacies within TRICARE Region Two.

Table of Contents

Outpatient Pharmacy

Civilian Prescription Pathway Process Improvement

Introduction

Naval Medical Center Portsmouth is one of the Navy's three largest Medical Treatment Facilities (MTF). The Medical Center's combined tertiary care eligible beneficiary population exceeds 400,000. The Commander of Naval Medical Center Portsmouth also serves as the Lead Agent for TRICARE Region Two. The Medical Center itself is a 363-bed facility with a defined beneficiary population of over 300,000 (Naval, 1996).

The Medical Center's Fiscal Year 1997 budget was $169 million excluding military labor. Of this amount, the Medical Center's 1997 budget for pharmacy expenditures was approximately $36 million dollars or 21% of the Fiscal Year 1997 budget. This expenditure accounted for both inpatient and outpatient pharmaceuticals consumed within the Medical Center and the Medical Center's seven branch medical clinics located throughout the Tidewater area.

Pharmacy expenditures for just the Medical Center, not including its Branch Medical Clinics, for Fiscal Year 1997 were $19 million dollars. This figure accounted for both inpatient and outpatient pharmacy expenditures. Of the $19 million dollars spent, outpatient pharmacy expenditures were approximately $12 million dollars (NMPC Pharmaceutical, 1997). Of the total

outpatient prescriptions filled at the Medical Center, twenty-nine percent were civilian provider written honored prescriptions (Alexander, 1997). With this large volume of civilian prescriptions being filled, a tremendous opportunity exists to collect third party resources from other health insurers whose beneficiaries utilize the Medical Center for obtaining pharmaceuticals through its outpatient pharmacies.

Conditions which Prompted this Study

There are many conditions that prompted this study. First of all, leadership recognizes that necessary changes need to occur within the Medical Center to transform aspects of the current military healthcare system towards a more managed care model. This means providing the right care by the right provider in the right place at the right price while properly managing key components of access, quality, and cost. The pharmacy benefit cannot be excluded from these changes. Pharmacy benefits in a managed care system play a significant role in the delivery of high quality patient care.

From Admiral Rowley, the Medical Center's Commander, down through the pharmacy technician, it is realized that changes must continue to occur within the Medical Center to improve the delivery of goods and services from the outpatient pharmacy. With tighter budgets, capitation, and pressures to induce greater

cost controls, continual improvements within the pharmacy are going to be necessary. These improvements will help leaders and managers within the pharmacy to contend with other changes that are affecting the military healthcare system. Pharmacy costs will continue to rise and our reliance on the pharmacy will increase as the Military Health System (MHS) transforms more towards a managed care operated model. Unless the MHS changes to reflect current methodologies for providing health care services, the system will fail to provide cost efficient and effective healthcare services.

For the Medical Center, the pharmacy operates as a tremendous cost center and not a revenue center. Pharmacy costs are directly linked to healthcare providers and the demand they create for pharmacy goods and services. Rarely do pharmacies generate demand for their own services. The Medical Center's demand for pharmacy goods and services are generated within the Medical Center from its own healthcare providers and outside the Medical Center from those beneficiaries who utilize other health care providers within the civilian sector. Often, these beneficiaries maintain other health insurance (OHI) and have their prescriptions filled at the Medical Center's outpatient pharmacy.

Current federal regulations prohibit curbing pharmacy entitlements to the MHS beneficiary population, so leaders and managers in and outside the pharmacy must continue to seek more

effective and efficient means to provide pharmacy goods and services. This is especially true in an environment that is undergoing so much change and where costs of pharmaceuticals are increasing ten percent each year which is well above the inflation rate. This environment includes adapting to the changing needs of the customer and adopting more managed care ideas and philosophies.

The Medical Center's Pharmacy Department has taken aggressive steps to transform itself from a product-focused service towards a more patient-focused service provider. These changes have been ongoing for the last couple of years and are geared towards managing the practice of the pharmacy in a more managed care environment (Alexander and Nolan, 1997).

Ancillary Directorate and Pharmacy Department leadership have transitional business re-engineering teams in place to prepare for future opportunities that will be presented by the opening of a new acute care facility (ACF). In the summer of 1999, a new acute care facility will open and replace the existing Medical Center. This facility will be named the Charette Health Care Center and will maintain a 320-bed capacity that will provide state-of-the-art care in many areas of medicine. It is recognized that the new pharmacy space and structural design of the new ACF will facilitate and enhance the pharmacy's ability to expand services in support of patient focused care (Alexander and Nolan, 1997).

Leadership within the Medical Center realizes that business practices and processes throughout the Medical Center, as well as within the pharmacy, have to be examined, improved, and changed to better reflect more up-to-date business practices that exist in a managed care environment. Doing business the same old way is not good enough anymore. Leadership is all too aware of limited budgets and resources, capitated budgets, managed care contracts, and other changes which are rapidly occurring within the MHS. These changes are transforming the MHS.

One business process that needed to be examined, improved, and changed is the Medical Center's outpatient pharmacy civilian prescription pathway. Currently, the process is minimally automated and the means for which data is collected is very cumbersome to the beneficiary, pharmacy staff, and the third party collections department.

Beneficiaries are required to manually fill out a Department of Defense (DoD) mandated encounter form (Attachment One) for third party collection information every time a prescription is filled or refilled in the outpatient pharmacy. This is performed whether or not the beneficiary has third party insurance. If the beneficiary returns the following day with a new prescription, a new encounter form must be filled out regardless of a previous visit to the outpatient pharmacy.

Beneficiaries are annoyed with the DoD encounter form, often refuse to fill it out, and usually don't have all the

necessary information needed to complete the encounter form. Often times, the beneficiary does not even know their third party insurance policy number. The physician's printed stamp on the prescription is often missing or illegible to read by the pharmacy staff. The physician's signature is not only required by law, but is needed to process any third party insurance claim. In some cases, beneficiaries also deny the possession of third party insurance partially due to the encounter form and a general misunderstanding or lack of knowledge concerning their third party insurance and benefit use. The misunderstanding seems to be that if beneficiaries provide OHI information, their health insurance rates will go up, which according to the Third Party Collection Program, is not the case.

The third party collection process involves the pharmacy department in many ways. Behind the pharmacy counter, when the pharmacist identifies the patient through the Composite Health Care System (CHCS), the beneficiary is only electronically screened for known allergies. The CHCS, through the Patient Administration Module, offers additional means for gathering data that would help obtain third party insurance information. Neither the pharmacy or third party collection department has pursued this option. Therefore, no other beneficiary information is queried from CHCS to determine whether or not the beneficiary has third party insurance. The current perception or belief from leadership within the pharmacy department is that if additional

information is obtained through CHCS to determine if the beneficiary has third party insurance, waiting times would be longer, more work would be added to pharmacy staff, and beneficiary dissatisfaction would increase.

The Medical Center's outpatient pharmacy, on average, processes in excess of 30,000 prescriptions a month (Nolan, 1997). Every aspect of dispensing medications and filling prescriptions must be considered. This includes time spent in line, time spent waiting for the prescription and the time spent at the window with the pharmacist. Obtaining OHI through CHCS or other means has been unknown as well as the time it takes to get this information. Waiting times are important to the MHS beneficiary. It is expected that the service being provided be performed fast and efficiently. So it is a very important consideration that must be weighed very carefully when expanding the duties of the pharmacist, especially if the pharmacist is required to spend additional time to input or abstract additional beneficiary data from CHCS. This was a critical area where a balance had to be sought between all parties involved.

The problem is further extended to billing clerks within the third party collection's office and the procedures they employ to process claims. The billing clerks are required to review all encounter forms manually and separate those claims that qualify for third party insurance reimbursement. This often results in hundreds of manual reviews a day, creating tremendous backlogs.

This manual review process is labor intensive, slows down reimbursement, and does not support good business practices. In addition, all third party data are entered in CHCS through the third party collection office. Eliminating the backlog is essential as part of revising the outpatient pharmacy civilian prescription pathway. Data must be entered into CHCS quickly to reflect current up-to-date beneficiary data. If not, the beneficiary's could be asked to fill out the third party insurance forms until CHCS reflects the OHI changes. The current procedures within this department are very time consuming.

When third party collections can be identified, encounter forms are often lacking the information necessary to process the claim. Missing beneficiary signatures, policy numbers, policy names, and required physician signatures are often missing. This requires the billing clerk to expend additional time obtaining such information to process the claim. The volume of third party insurance claims for outpatient civilian prescriptions alone was over 30,000 for Fiscal Year 1997. This volume of claims is considered significant enough to have a viable working process (Marshall, 1997). Current technologies exist within the Medical Center to improve this process.

The Medical Center's Command Evaluation Department conducted an internal audit, which revealed that from January 1997 to April 1997, there were 5,375 prescriptions billed to third party payers. This number did not include the thousands more, which

were backlogged from the previous year. Insurance claims for prescriptions are up to 12 months behind in outpatient billing. According to billing technicians, prescription drug claims more than 12 months old are not being processed due to the sheer backlog of claims on record. An undetermined amount of money is being lost because of this backlog (Command, 1997).

As mentioned already, conditions prompting this study are significant and have the attention of leadership throughout the chain of command. There exists the opportunity to improve the current outpatient pharmacy civilian prescription pathway that would result in numerous benefits to all parties involved.

Statement of the Problem

The problem exists with the current outpatient pharmacy civilian prescription pathway currently being utilized at the Medical Center's outpatient pharmacy. This graduate management project determined if the pathway could be improved. The current pathway is outdated and does not incorporate current methodologies and technologies available in today's MHS. The outpatient pharmacy civilian prescription pathway needs to be examined beginning from the patient's first encounter with the outpatient pharmacy up through those departments that interact as part of this pathway. Departments affected by this pathway

include the Resource, Materials Management, and Management

Information Departments along with the Pharmacy department.

The outdated pharmacy pathway exacerbates beneficiary

dissatisfaction, reduces pharmacy staff efficiency, wastes

resources, and tarnishes the image and business practice dealings

between the Medical Center and other health insurers. In

addition, this outdated pathway directly affects the quality,

access, and cost of providing pharmacy goods and services to the

beneficiaries the Medical Center serves.

Literature Review

The literature review for this Graduate Management Project

was limited in nature. Third party collections are not limited

to just the MHS. Third party collection is a standard business

practice performed within the civilian healthcare system. The

current MHS third party collection system is different simply by

federal regulations that govern DoD third party collections. For

example, inpatient third party collections are bundled and not

allowed to be separated. A pharmaceutical charge over $25 has to

occur before collection can be made, and DoD annually provides a

list of the services that can be billed. This list of billable

services is not inclusive of all healthcare services, just those

selected by DoD for collection. Several interviews with senior

leaders were conducted within the Medical Center and an expressed

concern over this problem was reiterated over and over. Along with those interviewed, the researcher felt strongly that this issue warranted a review to help resolve problems with third party collection. Navy directives and correspondence were reviewed as part of the literature review to ascertain current policy and guidance concerning third party collections and current pharmacy practices within DoD.

Change within Navy Medicine is supported at the top with the Surgeon General of the Navy and the Navy Medical Department's Fiscal Year 1997 Annual Performance Plan. This plan was written to support specific strategic goals that are designed to empower everyone within the Navy Medical Department. Navy Medicine's Annual Strategic Plan gives five Strategic Goals that will guide the organization towards its future vision. This vision being one that empowers Navy Medicine to be the preferred source of healthcare, where professional growth and satisfaction are achieved, where Navy Medicine becomes a system of excellence, where Navy Medicine becomes fully capable to meet the comprehensive healthcare needs of both Sailors and Marines, and lastly for Navy Medicine people to view themselves as the finest health care team. The five specific goals of the plan are; Readiness, People, Technology, Stewardship, and Health Benefit (Med-08, 1996).

All of these goals are significant and each interlinks with each other to help achieve the vision. The researcher believes

that two of the most important goals are technology and stewardship. Technology integration and how information is managed within the Navy Medical Department will transition Navy Medicine forward and will allow maximization of mission accomplishment, especially as the MHS becomes managed care focused. The stewardship goal allows taking responsibility for resources and employing methods which lead to more effective and efficient management and use of constrained financial, personnel, facility, and logistical resources (Med-08, 1996). Reducing the risk from the system and placing it on leaders and managers within Navy Medicine is part of these goals and a key component to future success. The Navy's strategic plan is designed to assist and give guidance towards Navy Medicine's future vision. The role Navy Medicine chooses to take and the changes made will be greatly reflected in a more modern healthcare system within Navy Medicine and the MHS.

Identifying necessary changes and making improvements to the current health system will become instinctive to survival. The system is large and in many areas, changes and improvement will be accomplished one project at a time. This kind of change is witnessed throughout the Medical Center and is part of the Medical Center's progressive transformation to managed care. The Medical Center's Pharmacy Department is undergoing these incremental changes, and in many ways is leading the way.

Pharmacy costs are rising throughout the DoD, both through direct care facilities and through services provided by our Managed Care Support contractors. There are numerous causes for the increases, including rising drug prices, increased utilization, prescribing habits, poor utilization management and disease state management, and increased use of the high technology/high cost drugs. In the past, no Tri-Service standards have been established for reviewing pharmacy costs. The use of the pharmacy cost reporting tools currently available through CHCS has been dependent upon the initiative of the pharmacist. CHCS reports are reviewed with interest by treatment facility commanders to gain at least some insight into utilization of the biggest supply expense in Medical Treatments Facilities, pharmaceuticals (OASD [HA] Pharmacy, 1997).

The importance of understanding pharmacy costs and prescribing practices, along with better business practices will become extremely valuable as the MHS transitions into a capitated environment. The use of information and what can be obtained from existing data can also help leaders within the MHS make better and more informed decisions. These decisions will ultimately lead to higher success rates in managing all aspects of the MHS.

As the nation's health care system changes, so will the DoD health care system. Initiatives and policies concerning business practices and the pharmacy benefit are ongoing within the DoD.

Currently, all MTFs should be accomplishing Pharmacy Price Analysis on generically equivalent drugs at least annually. It is not known if Pharmacy Price Analysis is conducted throughout the MHS. However, it is being conducted within Region Two MTF pharmacies (Nolan, 1997). The goal of this policy is for the MHS to reduce the cost of drugs dispensed from DoD pharmacies by $10 - $15 million a year (OASD [HA] Policy, 1997). Basically, the pharmacy price analysis tool is utilized to determine if generically equivalent drugs can be utilized instead of more costly drugs. This price analysis tool will help pharmacists and MTF commanders live within their capitated budgets.

There also exists Tri-Service Policy Guidance. This guidance reflects the expertise of an Ad Hoc Department of the Defense Pharmacy work group that was established in 1993 by the Office of the Secretary of Defense (Health Affairs). The purpose of Tri-Service Policy Guidance is to establish and provide standardized guidance for all DoD Pharmacy operations. This guidance applies to all Department of Defense Medical Treatment Activities that provide pharmaceutical services (OASD [HA] Tri-Service, 1995).

Summarized, the overview of responsibilities is as follows:

1. The responsibilities of the MTF Commander are:

a. To ensure that the pharmacy is operated under the supervision of a Pharmacist in accordance with Federal Law, service regulations, and accepted standards of practice such as

those defined by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), and other professional organizations.

b. To ensure that staffing levels and funding are appropriate to meet workload requirements.

c. To ensure that drugs approved by the Food and Drug Administration are authorized for use and that continuing education opportunities are made available to all pharmacy staff to update and increase their knowledge of current trends in pharmacy practice.

2. Responsibilities of the Pharmacists are:

a. To ensure the facility provides pharmaceutical care consistent with service regulations, medical staffing, and the standards of practice defined by the JCAHO and other pharmacy organizations.

b. To ensure security measures for pharmaceuticals and ensure that current drug information is maintained and distributed to medical staff and patients.

c. To ensure maintenance, and publication of a MTF formulary or drug list, using the Tri-service Formulary as a core, or accepted drugs for use in the facility.

d. To ensure that programs are established which ensure patient counseling services are provided to beneficiaries.

These policies are generic and are easily adopted amongst the services. All services are to adhere to these policies, but

business practices can vary. The variations were discovered after visiting the 1st Fighter Wing Hospital Pharmacy at Langley Air Force Base and McDonald Community Hospital Pharmacy at Ft Eustis. The basic or standard Tri-Service policies are adhered to, but different business practices were noted concerning third party collections and their migration towards a more managed care environment.

The pharmacy at Langley does not have a pro-active outpatient third party collections program. If the beneficiary has made it known that they have third party insurance through an inpatient visit, this information is queried from the outpatient pharmacy through CHCS. Or, if a beneficiary volunteers third party information at the outpatient pharmacy window, it is taken and processed accordingly with third party collections so a third party claim can be processed. Any beneficiary who seeks to fill a civilian provider written prescription at Langley will meet no requirement to divulge any third party information. Basically the burden of providing third party insurance information lies voluntarily with the beneficiary (Wheeler, 1997).

For Fiscal Year 1997, Langley had a $7.5 million dollar pharmacy budget. Civilian providers outside the MTF wrote approximately 40 percent of all prescriptions filled through Langley's outpatient pharmacy. Even without an active third party collection mechanism, Langley's pharmacy billed $144,000

for pharmaceuticals and recaptured $67,000 of the billed amount
(Carter, 1997).

There appeared to be a very cooperative spirit between
Langley's hospital third party collections department and the
pharmacy. Their system of collection was simple and sufficiently
performed. The pharmacy department felt they were adequately
funded and beneficiary needs were being met. Therefore, there
didn't appear to be the motivation to have an aggressive
outpatient pharmacy third party collection program. Any
resources obtained as a result of third party collections through
the outpatient pharmacy were returned to the overall budget of
the hospital.

The researcher's visit to McDonald Army Community Hospital
outpatient pharmacy at Ft Eustis found that their third party
collection program was nearly non-existent. Encounter forms were
unavailable for beneficiaries, and the beneficiary was not even
queried for any information regarding third party insurance. If
through an inpatient visit, the beneficiary divulged information
concerning third party insurance and utilized the outpatient
pharmacy, reimbursement was sought.

For Fiscal Year 1997, Ft Eustis pharmacy budget was 3.7
million dollars. Approximately 30 percent of all outpatient
pharmacy prescriptions were civilian written outside the MTF.
The relationship between the hospital's third party collections
department and the pharmacy seemed somewhat uncooperative.

Divisions of work concerning data gathering for third party collection seem to be the obstacle. Each department claimed they didn't have the manpower to gather and input third party insurance data into CHCS. Any resources re-captured through the outpatient pharmacy from third party collections were returned back to the hospital's budget (Goode, 1997).

Visits to two other treatment facilities within Hampton Roads at Air Force and Army healthcare facilities gave further insight on how different business practices and attitudes concerning third party collections can be. Even their use of CHCS and obtaining beneficiary profiles differed from that of the Medical Center. There was no standardization found from one MTF to another, just basic adherence to Tri-Service pharmacy policies.

There is Tri-Service prescription policies that govern prescriptions written by civilian providers. As of July 1995, the Assistant Secretary of Defense, Health Affairs reiterated policy concerning prescription filling within DoD pharmacies. Prescriptions from MTF credentialed providers for formulary drugs will be honored. Prescriptions for formulary drugs written by civilian practitioners for eligible beneficiaries will be honored as well.

The pharmacy may not curtail or withdraw civilian prescription service without prior approval of the respective service Surgeon General. The term civilian practitioner includes

doctors of medicine, osteopathy, dentistry or podiatry who are licensed without limitation to practice in their specialty. In addition, civilian physician extenders may also prescribe medication when authorized by the state in which the MTF pharmacy is located (OASD [HA] Tri-Service, 1995). Currently, the policy concerning civilian written prescriptions is clear. MHS pharmacies will honor these prescriptions and as managed care continues its evolution and beneficiaries become more cost conscious, this trend could increase.

For the foreseeable future, third party collection policies will remain in effect. MTFs will continue to make every attempt to collect from third party payers. However, in February of 1997, there was new policy governing this role. The policy stated that the DoD strongly encourages the privatization of non-core competencies performed by DoD agencies. The policy further stated that the business of the MHS is to support the readiness mission and provide beneficiaries quality patient care in the most efficient manner during peacetime. The policy stated that the business of billing and collecting is not a core competency of the MHS. Therefore, as a result of this policy, the function of billing and collecting will be privatized (OASD [HA] Policy for Privatizing, 1997). This is only one example of how the MHS will continue to change. As the MHS continues to change, the Armed Services should continue to find themselves performing

those services they are good at delivering and finding better ways to accomplish those services they do not perform very well.

The future and the way the MHS will be funded will affect the entire process of how healthcare services are delivered to beneficiaries. The MHS environment is typically characterized by increasing costs and limited budgets. The reasons for the rapidly rising costs are numerous and often complex. However, it is important to recognize that the current financial structure plays a role in the inflationary trend often observed within the MHS. Military departments traditionally programmed and budgeted for health programs on the basis of historical resource consumption and workload trends. A limitation to this budgetary approach is the built-in incentive to produce more services. With capitation, budgeting and allocation methodologies provide significant disincentives for efficient use of limited resources (OASD [HA] Policy Paper, 1997). The concept of capitation is an important strategy for containing the costs of healthcare and works hand in hand with third party collections.

Starting this Fiscal Year 1998, the MHS moved forward with its next generation of capitation based resource allocation. This move has been consistent with the evolutionary development of the TRICARE program. The main reason for this change ensures that the capitation method used to allocate resources to MTFs provides incentives to encourage every commander, provider, and decision maker to be fully accountable for delivering high

quality, cost effective health care services to beneficiaries. This means that the financing system must strive to keep pace with the health care delivery system's progress.

Enrollment Based Capitation (EBC) should empower MTF commanders with full accountability for all resources needed to support their enrolled beneficiary population. Incentives will be provided to produce or procure high quality, cost effective, and clinically appropriate health care services at every organizational level throughout the MHS (OASD [HA] Policy on Medical, 1997).

The Office of Assistant Secretary of Defense Health Affairs (OASD (HA)) capitation plan will structure the MHS in a manner consistent with a managed care concept. As defined by OASD (HA), managed care is defined as a system of healthcare delivery that influences the utilization of services, costs of services, and measures of performance. The ability of the MHS to successfully compete in this environment lies in its ability to manage access, quality, and cost. Managed care offers the incentive and opportunity to develop and implement strategies such as clinical guidelines, outcomes measurement analyses, and the use of operations research techniques to better meet the needs of the beneficiary population (OASD [HA] Policy Paper, 1997).

Capitation must be supported by all within the MHS. Dependency and reliance on automated information systems processes will also increase as the MHS evolves more towards

managed care and capitation. It will be the responsibility of everyone to help develop improved capabilities, assess and estimate costs for MTFs, and utilize current data to help MTFs compete successfully in a managed care environment.

One of the largest information systems currently in use throughout the MHS is CHCS. CHCS is a comprehensive medical information system designed and developed to provide automated support to military MTFs throughout the world. The system is composed of integrated modules that, when activated either together or independently, support high volume work areas within the MTFs and enhance communications between support areas that will be critical under a capitation system (The Composite, 1997).

Medical data processing capabilities are being acquired to assist the healthcare provider and health care administrators in the management and delivery of quality care. CHCS supports the administration and delivery of healthcare in MTFs. The integration of this information system means that all data concerning a patient need only be entered once, authorized users have access through the system to all data needed to perform their functions, and all functions are available to authorized users (The Composite, 1997).

Of significance to this study is CHCS' ability to enter, store, manipulate, and retrieve beneficiary registration data from one database. CHCS is also able to perform Defense Enrollment Eligibility Registration System (DEERS) checking,

Pharmacy, Medical Services Accounting and integrate with other standard DoD and Military automated information systems.

For the foreseeable future or until the DoD incorporates another health data management system, CHCS appears to be the system of choice for managing our MHS data. In fact, CHCS is one of the nations most developed integrated healthcare information systems. CHCS is continually updated and improved. There is pre-planned product improvements for CHCS which will enable users to make data specific changes to individual patient records which currently are not part of the original functional baseline of CHCS. Through this improvement, patient data should be more efficiently captured and storage of patient specific data should be easier to store in the patient's electronic record. This data derives largely from the CHCS Managed Care Program, which includes such things as other health insurance, enrollment data, and third party collection support. Some of the major technical design objectives for CHCS are ease of use, minimal program risk, ease of operation, flexible system configuration to support future enhancements, and reliability and availability greater than 99% (The Composite, 1997).

With the MHS rapidly transforming itself and becoming more competitive, fiscal policies will be relied upon much greater as everyone becomes more accountable for how scarce resources are managed. It is important that the MHS maintain programs that work and that our beneficiary populations are educated concerning

healthcare system changes that affect them. The Third Party Collection Program is just one of those programs.

Title 10 United States Code clearly defines third party collecting pertaining to medical and dental care. "In the case of a person who is a covered beneficiary, the United States shall have the right to collect from a third party payer the reasonable costs of health care services incurred by the United States on behalf of such person through a facility of the uniformed services to the extent that the person would be eligible to receive reimbursement or indemnification from the third party payer if the person were to incur such costs on the person's own behalf. If the insurance, medical service, or health plan of that payer includes a requirement for a deductible or co-payment by the beneficiary plan, then the amount that the United States may collect from third party payer is the reasonable cost of the care provided less the appropriate deductible or co-payment" (Title 10 USC, 1995).

The law is clear and unfortunately, many of our beneficiaries see laws such as these as reduction or erosion of entitlements promised as part of service related benefits. Implementing and enforcing policies and programs pertaining to third party collections will require that beneficiary populations be educated concerning these policies and leadership's commitment to enforce such policies.

Important terms and their definitions as defined by law are important to recognize and understand as they pertain to third party collections. The official term "third party payer" means an entity that provides an insurance, medical service or health plan by contract or agreement, including automobile liability insurance or no fault insurance carrier. The term "insurance, medical service, or health plan" includes a preferred provider organization and an insurance plan described as Medicare supplemental insurance. The term "healthcare services" includes products provided or purchased through a facility or the uniformed services (Title 10, 1995). These terms should be understood and known how they apply to services rendered which qualify for third party collection.

Many of our beneficiaries are increasingly possessing third party insurance through spouse employment and often as second career benefits offered through employers. As health care systems throughout the country change and implement tighter fiscal controls to curb beneficiary behaviors and utilization of healthcare resources, these changes will affect those service-related beneficiaries who will try and seek out "free" care through the MHS. Leadership must seek better management of reimbursement programs.

Purpose

The purpose of this graduate management project was to examine and re-engineer the current outpatient pharmacy civilian prescription pathway for filling civilian prescriptions. Through this project, examination, improvements, and changes are suggested which would improve and significantly enhance the current civilian prescription pathway.

Additionally, this project identifies methods to reduce and eliminate the current backlog of claims and meet future requirements to process outpatient pharmacy third party claims. This study was not limited to just the outpatient pharmacy and the third party collection department. This study enabled the researcher and others to better understand and utilize CHCS within the Medical Center. Methods to enhance beneficiary care, effectively use information systems, and improve business practices that rely on information systems, were identified.

As the Medical Center continues to move closer towards a managed care model, reducing costs and capturing costs have become a greater part of what leaders and managers are involved with on a day to day basis. This graduate management project focused on improving the outpatient pharmacy civilian prescription pathway centered on the components quality, access, and cost.

Methods and Procedures

This graduate management project examined each step within the current outpatient pharmacy civilian prescription pathway. The components of the civilian pathway were studied utilizing a qualitative approach. The current civilian prescription pathway was examined step by step to determine where the most appropriate changes could be made. Through this approach, the researcher obtained a workable and practical solution.

Subject matter expertise was sought from within the Ancillary and Resource Directorates, Management Information Department, and Pharmacy Department. Individuals within these departments were utilized to identify other obstacles, issues, and problems that resulted in trying to change or modify the current outpatient pharmacy civilian prescription pathway. Through the cooperative effort and input sought from key individuals within these Directorates/Departments, a workable solution was obtained.

A review and study of all the pathway steps involved with the outpatient pharmacy civilian prescription pathway and the third party collection process surrounding this pathway were analyzed and reviewed. Beneficiary and departmental input identifying other issues relating to this issue was also sought.

The feasibility of not having the beneficiary fill out the encounter form was explored. Alternatives were developed, which

include better form instructions, form reduction, form redesign, or other minor form modifications. This was accomplished within the guidelines of all current third party collect program regulations.

The use and coordination of information, along with the sharing and generation of information, was developed utilizing CHCS and the current modules CHCS employs within the Medical Center. Close liaison with the Medical Center's Management Information Department was established which helped resolve questions and issues that evolved related to the use of CHCS within the pharmacy. As part of better utilizing CHCS with the civilian prescription pathway, a time study was conducted to determine the actual time added to the process by checking OHI through CHCS.

The Results

Appendix two illustrates the current outpatient pharmacy civilian prescription pathways. Appendix three illustrates the revised civilian prescription pathway. The revised pathway incorporates a more streamline approach when filling civilian prescriptions which would enhance beneficiary satisfaction, promote pharmacy efficiencies, and enhance the overall third party collection process for the outpatient pharmacy. The revised pathway eliminates some pathway steps and recommends changes to other pathways. These changes reflect a different approach in which the pharmacy fills a civilian prescription and

how the beneficiary obtains their prescription. The entire pathway was examined from beginning to end. It is noted that not every pathway step needed change. Moving pathway steps around to accommodate the recommended changes to other pathway steps was performed. The lower half of the current pathway, where the actual mechanics of filling the prescription are being performed, did not need any change. These functions are performed extremely efficiently.

Changes made to the pathway steps are highlighted with blue text. These changes are suggested as a result of careful examination into the Composite Health Care System, Third Party Collection process, current prescription procurement methodology, and staff and beneficiary input. These changes carefully considered beneficiary satisfaction, pharmacy workload, and the third party collection process. If the revised pathway is implemented, good outcomes can be anticipated.

Discussion

The current civilian prescription-processing pathway consists of eight major pathway steps. Each of the pathway steps was qualitatively reviewed beginning with the first pathway step. The first pathway step begins when the beneficiary arrives at the pharmacy window. Currently, the Medical Center's pharmacy staff is incorporating a managed care model in the delivery of pharmacy

goods and services. The beneficiary's encounter at the pharmacy window is very customer service oriented.

Waiting times are minimal and often a pharmacist is the one who takes care of the beneficiary from beginning to end. At this point the pharmacist provides counseling and serves as the key individual in the dispensing of pharmaceuticals. Beneficiary questions are answered and many problems concerning medication doses and side effects are effectively dealt with during this pathway step. No suggestions or recommendations for change can be offered or suggested for the first pathway step.

The second pathway step involves screening the prescription for accuracy and correctness. At this point the prescription is screened for the correct beneficiary name, doctor's signature and phone number, and the correct prescribing regimen for the medication being requested. If there is a problem, the ordering physician is contacted either by the beneficiary or the pharmacist so the error can be corrected. If missing information or changes to the prescription can be made, the pharmacist proceeds to the next pathway step. If the needed information cannot be obtained or the physician does not approve any necessary changes, the prescription is returned to the beneficiary without filling the prescription. The beneficiary either returns to the prescribing provider or gets their prescription filled outside the MHS.

The flaw with this pathway step occurs when pharmacy staffs ignore the rules and continue to fill the prescription even though the prescription is missing essential information. This information includes the physician's name and telephone number. This interferes with the processing of third party insurance claims. Third party claim technicians must spend additional time contacting physician offices to get this information. The result from this translates to an increase in the time claims are processed and adds to an already backlog of claims. Overhead costs for the third party collection program are also increased due the additional effort expended trying to collect this information. Another missing component is that there is no referring mechanism that directs the beneficiary to alternative pharmacies outside the Medical Center to accommodate their needs.

The third pathway step has the beneficiary complete a Third Party Claims form. The beneficiary completes this form every time they have a civilian prescription filled. This is perceived by the beneficiary as a nuisance and consequently a problem to the process. As a result of this, beneficiaries often refuse to fill out the form or don't provide the necessary information needed to process a third party claim. Pharmacy staff continues to fill the prescription and often ignore the third party claims form themselves. When the form is passed on to the third party collection office for processing, missing information once again requires claims technicians to consume excess amounts of time

trying to obtain the needed information. This includes calling the physician's office for the information or querying other OHI databases for the information.

Having all beneficiaries complete the third party claims form also places a significant and unnecessary workload on claims technicians who have to manually review these forms one by one. Due to this, a long outstanding backlog in claims processing has persisted over the past year. Processing backlogged claim forms is often done utilizing overtime which also raises the overhead costs associated with the third party collection program. This makes this program more expensive to maintain than it should be.

The fourth pathway step is the point where pharmacy staff input beneficiary data and gain access through CHCS to verify eligibility of benefits. This input generates the prescription labels used for medication containers. It is also at this point when the beneficiary is screened for allergies and other drug interactions. The issue concerning this pathway step is the order in where it is placed. This pathway step needs to be further down the pathway after other more significant pathways steps have occurred. At this point of the pathway, it is assumed that the medication is in stock. If the medication is not in stock, all the above pathway steps have been performed unnecessarily and the beneficiary leaves the pharmacy very displeased.

During the fifth pathway step, pharmacy personnel actually take the label that has been printed and attach it to the medication container. Even at this point, it has not yet been determined if the medication is available. This pathway step also needs to be further down the pathway after other pathway steps have occurred. It has yet to be determined if even the medication is available.

Pathway step six is the point where pharmacy personnel actually take and fill the prescription. At this point pharmacy stock is acquired from the shelf or dispensing machines. If it is not available within the pharmacy, the supply department or another pharmacy is contacted to determine availability. If available through the supply department, it is obtained and the prescription is filled. If the medication is located at another pharmacy, the beneficiary is referred to that location. If the prescription is not available through the supply department or another pharmacy, two events occur. These events occur to meet the beneficiary's pharmacy needs. The beneficiary's physician is either called to approve a like substitute or the beneficiary is given a not in stock slip and called when it arrives. This pathway step needs to be one of the first pathways. The beneficiary should not have to go through all the previous pathway steps to get to this point to find out that the medication they need might not be available.

The methodology for procuring pharmaceuticals has changed within the Medical Center. The Medical Center's Material Management Department no longer maintains or stores bulk quantities of pharmaceuticals. Pharmaceuticals are ordered and purchased based on a just in time methodology as part of new material management practices (PRIME Vendor) to reduce costs associated with inventory. The Medical Center's formulary is also standardized throughout its outpatient pharmacies located within the Medical Center and its Branch Medical Clinics. If a medication is not available at the Medical Center, it is not available at other outpatient pharmacies. Referring the beneficiary to other pharmacies does not make sense.

If the medication is available, pathway steps seven and eight are followed. At these points checks and balances are performed which ensure accuracy and quality control. The prescription is then delivered to the beneficiary. Pathway steps seven and eight should remain the last steps in their current order. No improvements or recommendations are suggested.

The current outpatient pharmacy civilian prescription pathway is outdated. At one time it probably served as the correct pathway for filling civilian prescriptions. Many changes have occurred within the MHS and the Medical Center that warranted review of this pathway.

After careful review of the current outpatient pharmacy civilian prescription pathway, current material management

policies, changes to CHCS, and input obtained and observed from staff and beneficiaries, Appendix three illustrates a revised outpatient pharmacy civilian prescription pathway. The revised pathway addresses the concerns and issues identified with the current outpatient pharmacy civilian prescription pathway. The revised pathway incorporates recommended changes that streamline the entire pathway. Pathway changes are reflected in black outlined boxes with blue text.

Pathway step one of the revised outpatient pharmacy civilian prescription pathway remains the same without any change. It still remains the first pathway step that is performed very efficiently. The second pathway step involves patient insurance verification through CHCS. This process which is performed through CHCS adds only one additional keystroke line item to the current process. Making changes to the CHCS pharmacy menu was performed easily from the Management Information Department. CHCS System Analysis easily modified and made the necessary changes to the CHCS pharmacy menu which accommodated the changes suggested by this project. This process is shown below highlighting in blue the additional keystroke line item.

1. Log on: CHCS to access the Composite Health Care System

2. Key in: "PHR" for Outpatient Menu

3. Key in: "Scott" for Scott Center Location

4. Key in: "Device" for Label Printer

5. Key in: "PM" for Prescription Menu

6.   Key in: "PI" for Patient Insurance Information

7.   Key in: "SSN&BC" for Beneficiary Social Security Number & Beneficiary Code

8.   Key in: "RX" for new prescription entry and allergy check

By keystroking "PI," the patient insurance screen is invoked through CHCS.   Pharmacy staff can now have instant access to OHI information.   Having this access will virtually eliminate the use of the third party collection form.   When the patient hands over their prescription and identification card, the patient's social security number and beneficiary code are entered after keystroking "PI."   A screen is displayed which identifies whether or not the patient has OHI and whether or not it needs to be updated.   The only question pharmacy staff pose to the beneficiary is whether the information on the display screen is accurate.   If the OHI information is current the next pathway step in the process is performed.   If the OHI information is incorrect or is missing, at that time the beneficiary is requested to complete an OHI form.   This form has been redesigned and is illustrated in Appendix four.

The revised OHI form is shorter and requires the beneficiary to provide less information compared to the currently utilized third party claims form.   The revised OHI form uses common terms which are easier to understand and a print font that is easier to read.   Less information is required because CHCS contains most of

the information the older form requested. Since the revised OHI form is completed when needed, third party collection clerks don't have thousands of forms to individually review. All OHI forms that are submitted to the third party collections department indicate an action that needs to be taken to update CHCS and process an OHI claim.

With a significant reduction in the amount of OHI forms that need to be reviewed by third party collection personnel, the backlog should be greatly reduced and eventually eliminated. This should also save on overtime paid, save on claims clerk review times, and reduce the excess overhead associated with the third party collection program.

Remaining sensitive to additional workload requirements on pharmacy staff by adding additional tasks to the pathway was greatly considered. A time study was conducted to determine how much additional time is added to the process by adding one additional keystroke line item to the current CHCS keystroke process. Appendix Five illustrates the components of the time study and the results. The mean average time obtained from five randomly selected experienced pharmacy technicians who participated in the time study was a mean average of 10.8 seconds. As technician proficiency is gained with the addition of this additional keystroke, the average time should be reduced. This insignificant amount of time outweighs the total benefits of not adding this step.

Another significant factor which affects the time when obtaining beneficiary information from CHCS is how beneficiary information is keyed into CHCS. After observing pharmacy staff on numerous occasions, it was noted that no one way is utilized to access beneficiary information from CHCS. The fastest and most efficient way to access beneficiary information is by entering the beneficiary's social security number along with their beneficiary code, i.e. 123-45-6789 30. Accessing CHCS in this manner brings up the exact beneficiary profile. The need to scroll through numerous beneficiaries who share the same elements of a name or social security number is eliminated.

Pathway step two also identifies a mechanism for the beneficiary who refuses to complete the OHI form. The prescription is returned to the beneficiary and they are referred to see a Health Benefits Advisor. This avenue puts the beneficiary with an individual specifically trained to inform and counsel beneficiaries concerning their health benefits. The Health Benefits Advisor can explain the Title 10 law regarding the third party collections program and educate the beneficiary concerning these policies. If the beneficiary still refuses to provide the needed OHI information, the Health Benefits Advisor can explain benefits offered through CHAMPUS. Referring the beneficiary to the Health Benefits Advisor also alleviates the pharmacy staff from performing this function.

After OHI information is verified, pathway step three is performed to check pharmacy stock for the medication. If the medication is available, pathway step four is immediately followed. If the medication is not available, the physician who prescribed the medication is contacted to approve a like substitute. If the physician approves a substitution, pathway step four is immediately followed. If the physician does not approve a substitute, the prescription is returned to the beneficiary and they are referred to a TRICARE PRIME Network Pharmacy. This is another stopping point where the beneficiary can become dissatisfied with health benefits. If this occurs at this pathway step, the beneficiary is referred to a Health Benefits Advisor.

Pathway step four is the point where the prescription is screened for the required information to fill the prescription. It is during this pathway step where the beneficiary's physician is contacted if there is missing required information or if an error has been made in the actual prescription itself. If there are no problems, pathway step five is followed. If a problem is encountered and the physician cannot be contacted or the physician will not correct the prescription, the prescription is returned to the beneficiary and referred back to their physician.

Pathway step five is the point where pharmacy staff input into the computer the beneficiary's prescription and check for allergies. It is during this pathway step where prescription

labels are printed and applied to medication containers. Pathway steps six, seven, and eight are followed as illustrated in appendix three. Changes to pathway steps seven and eight were not made because they were not necessary.

Conclusions and Recommendations

In conclusion, and as a result of this study, the original premise of this study is posed again. Can the Outpatient Pharmacy Civilian Prescription Pathway be improved? The answer is yes and it has been clearly shown and substantiated through this graduate management project. If the revised outpatient pharmacy civilian prescription pathway is adopted and put into practice, both immediate and long term results would be obtained that would positively affect the quality, access and cost of beneficiaries obtaining their civilian prescriptions through the Medical Center's outpatient pharmacy.

Incorporating these changes can be easily performed. No approval needs to be obtained from DoD or Health Affairs and medical center CHCS computer specialists can easily make the necessary changes at no cost. No special training is needed. Training personnel would be minimal, not cost anything, and only consist of the time needed to explain the revised prescription pathway and the changes to be made. The recommended CHCS changes for obtaining OHI information can also easily be incorporated anywhere CHCS is employed and OHI is obtained. It is not

exclusive to the pharmacy. Other inpatient and outpatient areas can benefit. Electing to incorporate these changes will minimally impact the MTF from a cost, time, and resource standpoint. These changes offer tremendous potential for the improvement services, collectibles, and patient satisfaction.

One driving force into the examination of the current pathway was to increase beneficiary satisfaction. If the revised pathway is adopted, the researcher believes that beneficiary satisfaction would greatly increase. Increasing beneficiary satisfaction would be achieved by not having the beneficiary fill out the third party insurance form every time they used the outpatient pharmacy to have a civilian prescription filled. A shorter much more useful form would be utilized only when OHI information is missing or needs to be changed. When beneficiaries have to utilize the third party collection form, it has been designed to be much friendlier in language, content and size.

To inform beneficiaries of the changes made, it is recommended that the currently displayed civilian prescription pathway be removed and the revised pathway be displayed in a more prominent area where it can be easily seen by beneficiaries. Use of a more friendly and colorful pathway chart for display is highly recommended. It is also recommended that the changes the revised pathway incorporates be advertised in the Medical Center's newsletter. This publication would serve as an internal

media mechanism to inform Medical Center staff of the changes made.

To inform the beneficiary population within the catchment area concerning these changes, it is recommended that local military publications be utilized which target Region Two's beneficiary population. These publications would include the "Soundings," "Flyer," "Gator," and "The Flagship." These publications are distributed throughout the Tidewater civilian community and would serve as an appropriate media mechanism to reach beneficiaries who only use the Medical Center for such services.

The outpatient pharmacy and its staff would greatly benefit from the pathway changes. Not having to deal with beneficiary dissatisfaction and frustrations both related to the third party collection process would be a significant relief for pharmacy personnel. Incorporating the revised pathway would minimally affect the workload and as the pharmacy staff becomes more efficient working with the new changes, staff proficiency will increase. This was shown when studied through a pilot study at the Medical Center's Scott Center Outpatient Pharmacy.

Regardless if the revised pathway is adopted, it is recommended that pharmacy personnel adopt a single method for entering beneficiary information into the CHCS computer. Entering the beneficiary's social security number along with their beneficiary code retrieves the beneficiary record

significantly faster than methods currently being utilized. As part of this recommendation, CHCS training methodologies need to be changed in regard to how users are trained to use and access beneficiary data through CHCS. These areas would include the Naval School of Health Sciences where Corpsman are taught how to use CHCS and the Medical Center's Staff Education Training Department where CHCS training is provided to all other users of CHCS.

The researcher also recommends that deviations from any pathway to accommodate irate, noncompliant, or dissatisfied beneficiaries not be performed. Assisting this kind of beneficiary is better done with the Health Benefits Advisor. Health Benefits Advisors can calm and better educate our beneficiary population concerning the changes within the MHS. Another beneficial recommendation is that the revised pathway be incorporated at other Medical Center Branch Medical Clinics within Region Two and at other DoD outpatient pharmacies where civilian prescriptions are being filled. The revised pathway is not tailored exclusively to the Medical Center and its outpatient pharmacy operations. The revised pathway incorporates standard use of technologies that are located throughout all DoD outpatient pharmacy facilities. The forum to introduce the revised pathway could be through the TRICARE Mid Atlantic all Service Pharmacy meeting which is held monthly.

Another direct benefit that would be derived from incorporating the revised pathway would be the direct changes realized within the Third Party Collection Department. Sorting through piles of third party insurance claims and validating them one by one would be drastically reduced to only those that would need to be changed or added. The backlog of reviewing third party insurance forms should be eliminated. This reduction would not only save on resources utilized for overtime paid to review these forms, but would reduce the overhead that is associated with the third party collections program. Reducing the overhead associated with the third party collection program means greater resource returns for outpatient pharmacies.

The researcher recommends from this particular project that all other outpatient and inpatient areas within the Medical Center which collect beneficiary information concerning OHI be reviewed and evaluated to necessitate their need to use the current Third Party Insurance Collection form. CHCS can be utilized in all outpatient and inpatient areas to obtain OHI information through the same methods described within this project. It is also recommended that the Medical Center's Third Party Collection Instruction be re-written to reflect the changes made by adopting the revised pathway.

In an era of significant change within the MHS, everyone at all levels will need to be empowered to recognize areas within the military health system that can be changed to reflect more

modern business practices. This graduate management project provides just one example of identifying potential change. As members of the MHS, our success will rely heavily on those who are willing to take on the challenges of change more easily and be more willing to take risks. As health care professionals, our commitment is more than just quality, access, and cost. Our commitment extends to the beneficiary and doing the best we can in any given situation to ensure and deliver the highest level of patient care.

References

Albright, S. (Personal Communication, December 4, 1997). Interview at Managed Care Office, CDR Albright, Assistant Department Head, Naval Medical Center, Portsmouth, VA.

Alexander, M. B. (Personal Communication, September 5, 1997). Interview at NMCP with CAPT Alexander, Head of Pharmacy at NMCP.

Alexander, M. B. and Nolan, A. E. (1997) <u>Implementing Pharmaceutical Care in a 348 Bed Naval Medical Center.</u> Naval Medical Center, Portsmouth, Virginia.

Allen, F. (Personal Communication, December 17, 1997). Interview at Third Party Collection Office with Mr. Allen, Supervisor, McDonald Army Community Hospital, Ft. Eustis, Newport, News, VA.

Baugh, J. (Personal Communication, September 16, 1997). Interview at NMCP with LCDR Baugh, Outpatient Pharmacy Division Head at NMCP.

Bernardo, D. (Personal Communication, October 1, 1997) Interview at Outpatient Pharmacy with Mr. Bernardo, Outpatient Pharmacy Supervisor, McDonald Army Community Hospital, Ft. Eustis.

Bozman, R. (Personal Communication, August 17, 1997). Interview at NMCP with CAPT Bozman, Director Ancillary Services at NMCP.

References

Brown, G. (Personal Communication, December 18, 1997).
Interview at Outpatient Pharmacy with Ms. Brown, Pharmacy
Technician, Naval Medical Center, Portsmouth, VA.

Carter, M. L. (Personal Communication, September 25, 1997).
Interview at Outpatient Pharmacy with CAPT Carter, Officer in
Charge of Pharmacy Services, 1st Fighting Wing Hospital, Langley
Air Force Base, Hampton VA.

Command Evaluation Review (September 1997), Review of
Patient Billing & Collections Review Number 97-09, Naval Medical
Center, Portsmouth Virginia.

Commander, Naval Medical Center, Portsmouth, VA (1997).
Third Party Collections Program (TPCP). Naval Medical Center
Portsmouth Virginia Instruction 6010.5B.

Cook, G. (Personal Communication, February 11, 1998).
Interview at Scotts Center Outpatient Pharmacy, LCDR Cook,
Department Head, Naval Medical Center, Portsmouth, VA.

Creighton, J. (Personal Communication, September 16, 1997).
Interview at NMCP with HM2 Creighton, Outpatient Pharmacy
Technician at NMCP.

Dilbeck, T. (Personal Communication, December 18, 1997).
Interview at Outpatient Pharmacy with Ms. Dilbeck, Pharmacy
Technician, Naval Medical Center, Portsmouth, VA.

References

Edwards, W. (Personal Communication, December 18, 1997). Interview at Outpatient Pharmacy with Ms. Edwards, Pharmacy Technician, Naval Medical Center, Portsmouth, VA.

Golightly, C.K. 1981, Creative Problem Solving for Health Care Profesionals. Aspen Publications, Rockville, MD. 163-173.

Goode, D. (Personal Communication, October 1, 1997). Interview at Outpatient Pharmacy with Major Goode, Outpatient Pharmacy Department Head, McDonald Army Community Hospital, Ft. Eustis, Newport News, VA.

Hall, G. (Personal Communication, January 9, 1998). Interview at TRICARE Mid Atlantic Office with CDR Hall, Director Clinical Ancillary Services, Norfolk, VA.

Houseanzchp, H. (Personal Communication, November 25, 1997). Interview at Management Information Department with Mr. Houseanzchp, Computer Specialist, Naval Medical Center, Portsmouth, VA.

Laguitan, D. (Personal Communication, December 18, 1997). Interview at Outpatient Pharmacy with Mr. Laguitan, Pharmacy Technician, Naval Medical Center, Portsmouth, VA.

Marshall, P. (Personal Communication, September 23, 1997). Interview at NMCP with Ms. Marshall, Supervisor Third Party Claims Department at NMCP.

References

Med-08 Plans, Analysis and Evaluation (1996). <u>Fiscal Year 1997 Annual Plan</u>. BUMED Homepage [On-line]. Available: http://support.med.navy.mil/bumed/med-08/pi97.htm.

Naval Medical Center Portsmouth Pharmaceutical Month to Month Comparison FY 95 - FY 97 (1997). <u>FY 97 Report.</u> Portsmouth, VA: Author.

Naval Medical Center Portsmouth Public Affairs Office (1996). <u>Fact Sheet</u> (2nd ed.) [Brochure]. Portsmouth, VA: Author.

Nealy, J. (Personal Communication, November 26, 1997). Interview at Staff Education and Training Department with Mr. Nealy, CHCS Instructor, Naval Medical Center, Portsmouth, VA.

Nolan, A. E. (Personal Communication, September 5, 1997). Interview at NMCP with CDR Nolan, Assistant Head of Pharmacy at NMCP.

Office of the Assistant Secretary of Defense Health Affairs (1997). Policy on Medical Treatment Facility (MTF) Enrollment Based Capitation Resource Allocation for the Military Health Service System (MHS). <u>Health Affairs Homepage</u> [On-line]. Available: http://www.ha.osd.mil/hbp/capi9743.html.

Office of the Assistant Secretary of Defense Health Affairs (1997). Policy for Privatizing Billing and Collecting in Military Treatment Facilities. <u>Health Affairs Homepage</u> [On-line]. Available: http://www.ha.osd.mil.hsf/bill9730.html.

References

Office of Assistant Secretary of Defense Health Affairs (1995). Tri-Service Pharmacy Policy Guidance. Health Affairs Homepage [On-line]. Available: http://www.ha.osd.mil/tricare/pharmpol.html.

Office of Assistant Secretary of Defense Health Affairs (1997). Pharmacy Cost Reports. Health Affairs Homepage [On-line]. Available: http://www.ha.osd.mil/tricare/pharmcost.html.

Office of Assistant Secretary of Defense Health Affairs (1997). Policy on Conducting Pharmacy Price Analysis. Health Affairs Homepage [On-line]. Available: http://www.ha.psd.mil/projs/dmlss/pric9759.html.

Office of Assistant Secretary of Defense Health Affairs (1997). Policy Paper on Preparing the Military Health Services System (MHS) for Capitation-based Resource Allocation. Health Affairs Homepage [On-line]. Available: http://www.ha.osd.mil/hbp/cappol1.html.

Peterson, J. (Personal Communication November 25, 1997). Interview at Management Information Department, Mr. Peterson, Systems Analysis, Naval Medical Center, Portsmouth, VA.

Roney, C. (Personal Communication, December 18, 1997). Interview at Outpatient Pharmacy with HM3 Roney, Pharmacy Technician, Naval Medical Center, Portsmouth, VA.

References

Sarthou, W. (Personal Communication, January 1998). Interview at Baylor Resident's Office with LCDR Sarthou, Baylor Resident, Naval Medical Center, Portsmouth, VA.

The Composite Health Care System (1997). The Composite Health Care System (CHCS). US Army Aeromedical Center Homepage [On-line]. Available: http://198.250.183.60/chcs.htm.

Third Party Collections Program 27 Jan 1997, Naval Medical Center, Portsmouth Virginia Instruction 6010.1A

Thomas, C. (Personal Communication, August 22, 1997). Interview at NMCP with Mr. Thomas, Command Evaluator at NMCP.

Rowley, W. R. (Personal Communication, September 30, 1997). Interview at NMCP with RADM Rowley, Commander of NMCP.

U.S. Code, Title 10. Third Party Collections Pertaining to Medical and Dental Care. Health Affairs Homepage [On-line]. Available: http://www.ha.osd.mil/tricare/news/10usc109.html

Wheeler, T. (Personal Communication, September 25, 1997). Interview with Senior Master Sergeant Wheeler, Senior Pharmacy Technician, 1st Fighting Wing Hospital, Langley Air Force Base, Hampton VA.

Appendix One

NAVAL MEDICAL CENTER PHARMACY

PATIENT NAME:_____.
        Last   First   Middle Initial
SPONSOR'S SSN: _____-____-_____ PATIENT'S SSN: _____-____-_____.
NAME OF CIVILIAN PHYSICIAN THAT ISSUED PRESCRIPTION: _____

_____

DO YOU HAVE HEALTH INSURANCE? YES / NO

IF ANSWER IS "NO" PLEASE STOP HERE AND SIGN BELOW

HAVE YOU COMPLETED ONE OF THESE FORMS WITHIN THE LAST 6 MONTHS?

IF YES AND ALL INFORMATION IS CURRENT PLEASE JUST SIGN BELOW

FOR INSURED BENEFICIARIES:
By signing below I certify that the information provided concerning health insurance is true and accurate to the best of my knowledge. I understand that I will not be required to pay a deductible or co-payment. If there is a co-payment or deductible on my policy, the amount collected by the military treatment facility will be less any deductible or co-payment normally paid by me. **I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS MEDICAL INSURANCE CLAIM.**

SIGNATURE:_____ DATE:

HOME ADDRESS:_____
    (HOUSE #/STREET/APT #)   (CITY) (STATE) (ZIP)

HOME PHONE: (____)_____ WORK PHONE: (____)_____

SEX: MALE / FEMALE DATE OF BIRTH:_____

SPONSOR'S NAME:_____
    Last   First   Middle Initial

BRANCH OF SERVICE:_____

INSURANCE INFORMATION:
INSURANCE COMPANY NAME:_____
INSURANCE COMPANY ADDRESS:_____
INSURANCE COMPANY PHONE NUMBER: (____)_____

POLICY/ID NO.: _____GROUP NAME/NO.:_____
SUBSCRIBER'S   PATIENT'S RELATIONSHIP
NAME: _____ TO SUBSCRIBER:_____

Appendix Two

Current Outpatient Pharmacy Civilian Prescription Processing Pathway

Step 1

Patient Arrives at Pharmacy Window

Civilian Doctor

Step 2

| Return Rx to Patient and Provide a Copy of NMCP Formulary for Provider | ← | MD Able to Correct | ← | Call Physician or Have Patient Contact Physician | ← | Screen Prescription |

Step 3

Complete 3rd Party Claims Form

Step 4

Pharmacy Personnel Inputs Prescription into Computer or Reprints Label for POE

| Consult with Physician and Patient to Resolve Problem | ← | Prescription Screened for Allergies, Interactions, Overlaps, Duplication, and Phone # by Pharmacy Personnel |

None

Step 5

Pharmacy Personnel Takes Label From Printer and Matches up with Prescription

Label Correct

Step 6

Pharmacy Personnel Prepares to Fill Prescription

Medication in Stock → Call Supply, Bldg. 1, 10A. Or Scott Center

Give Patient NIS Slip & Obtain Phone Number → Obtain Medication Via Supply

Able to Obtain

Call Provider to Substitute

Step 7

Provider Willing to Substitute

Pharmacy Staff Completes Rx
1) Right Medication
2) Correct Label
3) Auxiliary Labels
4) Stamp Initials on Label or Filler

Call Patient When Medication Arrives

Pharmacist or Tech Checker

Correct → Pharmacist/Tech Checker Corrects

Step 8

Pharmacist or Tech Checker Stamps Name or Initials on Bottle and Prescription

Patient Receives Medication and Counseling Using PPCP Process and Patient Satisfaction Survey is Randomly Provided

Appendix Three

Revised Outpatient Pharmacy Civilian Prescription Processing Pathway

Step 1

Patient Arrives at Pharmacy Window

↓

Civilian Prescription Presented

Step 2

↓

Check/Verify Patient Insurance Information through CHCS

Return Prescription and refer to Health Benefits Advisor ← **No** ← Complete Other Health Insurance Form ← **No** ← Check/Verify Patient Insurance Information through CHCS

Yes

Step 3

↓

Check stock for Medication Availability

Call Provider to Substitute ← **No** ← Check stock for Medication Availability

↓

Provider Willing to Substitute → **Yes**

No

↓

Return Rx to Patient

↓

Refer to TRICARE PRIME Network Pharmacy or Mail Order Pharmacy

Step 4

Return Rx to Patient ← MD Able to Correct ← Call Physician or Have Patient Contact Physician ← **No** ← Screen Prescription for Required Information

↓

Yes

↓

Step 5

Pharmacy Personnel Inputs Prescription into Computer or Reprints Label for POE

Consult with Physician and Patient to Resolve Problem

Prescription Screened for Allergies, Interactions, Overlaps, Duplication, and Phone # by Pharmacy Personnel

None

Pharmacy Personnel Takes Label From Printer and Matches up with Prescription

Label Correct

Step 6

Pharmacy Personnel Prepares to Fill Prescription

Step 7

Pharmacy Staff Completes Rx
1) Right Medication
2) Correct Label
3) Auxiliary Labels
4) Stamp Initials on Label or Filler

Pharmacist/Tech Checker Corrects

Pharmacist or Tech Checker

Correct

Step 8

Pharmacist or Tech Checker Stamps Name or Initials on Bottle and Prescription

Patient Receives Medication and Counseling Using PPCP Process and Patient Satisfaction Survey is Randomly Provided

2

Appendix Four

Other Health Insurance Information

Patient's Name & SSN: _____
(Last, First, Middle Initial)

Sponsor's SSN: _____

Provider's name who issued prescription: _____

Insurance Company: _____ Policy/Group Number: _____

Address: _____

Phone: (_____)_____

Subscriber's Name: _____ Relation to Subscriber: _____

By signing below, I certify that the information provided concerning other health insurance is true and accurate to the best of my knowledge. I understand I will not be required to pay a deductible or co-payment. If there is a co-payment or deductible on my policy, the amount collected by the military treatment facility will be less any deductible or co-payment normally paid by me. I **AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS MEDICAL INSURANCE CLAIM.**

Signature & Date: _____

Appendix Five

Outpatient Pharmacy Civilian Prescription Pathway Time Study

Time Study Purpose
Document the average time added to the outpatient pharmacy civilian prescription processing pathway by adding the "PI" keystroke line item to the current CHCS process.

Beneficiary Data Gathering
25 beneficiary records were selected from a list of 895 CHCS beneficiary records that were drawn from the CHCS database in October 1997 who were known to have OHI. These 25 records were selected on a completely random basis. No specific selection criteria were needed for the time study. From records selected, the beneficiary's name along with their social security number and beneficiary code were placed on individual 3x5 index cards. No other information was placed on the card. This card would simulate the information provided on an identification card and/or prescription.

> John S. Doe
> 123-45-6789 20

Pharmacy Technician Selection
Five pharmacy technicians from the Naval Medical Center Outpatient Pharmacy were randomly selected by the Leading Petty Officer of the outpatient pharmacy to participate in the time study. The individuals selected were both civilian and military staff members with Military Health System pharmacy experience ranging from 2 to 8 years. All pharmacy technicians selected for the study were thoroughly familiar with CHCS and the current civilian prescription pathway.

Time Study Location
The time study was conducted in the outpatient pharmacy.

Time study instruments

A live CHCS terminal located in the outpatient pharmacy and a TIMEX sports stop watch for measuring time.

Time Study Variables Considered

Due to performance issues of the CHCS, NMCP's Management Information Department was contacted at the time of the actual time study to determine CHCS operating performance. CHCS on the day of the time study was running at optimum speed and no system changes were being made to CHCS that would affect the access and retrieval times of retrieving data from the CHCS.

Time Study Procedures

Each pharmacy technician received the same explanation of the time study. Each pharmacy technician was told how to access patient insurance information and was familiarized with the patient insurance screen and the OHI data that appeared on the screen. Each technician was told how to access the beneficiary's OHI information and walked through each step in the revised process. Each pharmacy technician also had three untimed walk-through to ensure system and pathway familiarity. Each technician was offered a time period to pose any questions and get answers to any issues surrounding the time study.

The time study was conducted in the same manner with each pharmacy technician. The only difference obtained would be the individual's speed and accuracy in using the CHCS terminal. Each pharmacy technician was told that they would be presented 25 cards with the beneficiary's name, beneficiary code, and social security number. The cards were placed on the desk top and from there, the pharmacy technician was told that the timer would be started once they key stroked the letters "PI" (patient insurance). The Pharmacy Technician was told that the timer would stop when they recognized the insurance information and asked the researcher whether the insurance information was accurate.

Time Study Time Frame

The time study was performed over a two-hour period on the same day.

Recording of Time Study Results

All times were recorded on the reverse side of each index card. Pharmacy technicians who participated in the time study were not made aware of other participant's times. This was done to reduce time achievement competition.

Time Study Results

	Tech 1	Tech 2	Tech 3	Tech 4	Tech 5	Avg. Total
Card 1	11	10	10	10	11	10.4
Card 2	12	11	11	11	11	11.2
Card 3	11	10	11	11	11	10.8
Card 4	11	10	11	11	10	10.6
Card 5	11	10	10	10	10	10.2
Card 6	10	10	9	10	10	9.8
Card 7	11	10	10	10	11	10.4
Card 8	8	8	10	9	12	9.4
Card 9	10	12	10	12	12	11.2
Card 10	10	9	9	10	10	9.6
Card 11	12	9	10	12	10	10.6
Card 12	10	9	9	10	12	10
Card 13	10	11	11	11	11	10.8
Card 14	9	8	10	12	10	9.8
Card 15	12	12	9	11	12	11.2
Card 16	11	10	10	11	11	10.6
Card 17	13	10	11	10	12	11.2
Card 18	15	10	12	11	11	11.8
Card 19	11	11	10	10	10	10.4
Card 20	12	9	11	11	12	11
Card 21	11	13	11	10	12	11.4
Card 22	14	12	11	11	11	11.8
Card 23	11	10	10	12	11	10.8
Card 24	10	8	9	12	12	10.2
Card 25	12	11	12	12	12	11.8
Mean Average	11.12	10.12	10.28	10.8	11.8	**10.8**

Technician
Average
Time

Tech 1	11.12
Tech 2	10.12
Tech 3	10.28
Tech 4	10.8
Tech 5	11.8

Combined Average Pharmacy Technician Time: 10.8